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THE BRITISH JOURNAL OF DERMATOLOGY

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THE BRITISH
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SEPTEMBER, 1908.

A CASE OF PEMPHIGUS VEGETANS.

By H. MacCORMAC, M.B.Edin.,
Demonstrator in Bacteriology, Middlesex Hospital.

The case to be recorded was admitted into the Westminster Hospital, under the care of Dr. R. G. Hebb, whose house-physician I was at that time, and to whom I am indebted for permission to publish the notes.

Mrs. F. M—, aged 23 years, admitted July 13th, 1905, died October 11th, 1905. She had borne two children, the younger at the time of admission being eleven weeks old. Both were in good health.

This latter labour had been prolonged, necessitating the use of forceps, but was otherwise uneventful, and the lochia appear to have been natural. There had been no miscarriages, and there was nothing of note either in her personal or family history.

The history indicated the existence of vesicles—"white-headed things"—having appeared on the genitals about nine days after child-bed, later spreading to the adjacent skin. These broke, but the raw surfaces did not heal; some of the vesicles became confluent before rupturing.

Then a number of vesicles developed in and around the mouth and nostrils, but the skin elsewhere, except about the genitals, remained clear. Soon the thighs were involved, chiefly over the adductor regions, then the back, chest and arms, in the above order.

Such are the main facts before admission. On that date bullæ or vesicles were scattered all over the body, also raw surfaces where the former had ruptured. Some bullæ contained a clear, others a turbid or purulent, fluid. The mouth and vaginal mucous membranes were involved, and a sero-purulent vaginal discharge was present. The temperature stood at 101·8° F., but in spite of this the patient showed no marked constitutional symptoms, her appetite was good, and she lay comfortably in bed. The heart and lungs were normal, and the urine contained no albumen.

In general terms it may be said that the skin condition became gradually worse until death on October 11th, although now and then some region showed a temporary improvement.

At one time there was a distinct lull in the storm, between August 3rd and September 15th. Before August 3rd the temperature had been about 101° F., but at this date it began to fall and remained, approximately, normal until September 15th, when it again rose and remained up until death, although this latter bout of fever averaged a lower degree than the former. This improvement was seen in all directions save in the skin condition, which still progressed steadily. As various brands of anti-streptococcic serum had been freely used one was inclined to attribute the improvement to this remedy.

Such is briefly an outline of events; below a more particular account is given.

July 21st.—Some of the raw surfaces had begun to weep or discharge; on others—especially in the axillæ and lower abdomen—a granulating or papillomatous condition was observed; the papillæ stood about a quarter of an inch above the surface.

July 24th.—New bullæ had appeared on the right forearm and hand. As the latter had become œdematous an incision was made, but no pus found.

August 5th.—There was a complaint of pain in both knee-joints, which had become puffy. No cardiac murmur.

August 14th.—A large number of raw surfaces resulting from ruptured bullæ began to show definite raised edges.

August 17th.—A marked increase in the fungating condition in the axillæ was noted.

August 20th.—A markedly purulent vaginal discharge was now present, and numerous crops of vesicles had been forming on the

[*Photograph by J. Parsons.*

TO ILLUSTRATE DR. H. MACCORMAC'S ARTICLE ON PEMPHIGUS VEGETANS.

genitals. At the same time the general bullous formation had been progressing.

October 2nd.—From this date onwards the progress was steadily down hill. Practically the whole trunk and extremities were covered with bullæ or raw surfaces, and on many of the latter fungating masses or thick impetiginous crusts had formed. The face did not escape and the mouth was involved. The purulent vaginal discharge had continued unabated. A most unpleasant odour, which had been very marked before, now became so intolerable that special isolation was necessary. Up to the very end new formation of bullæ continued on the few areas where free skin remained.

The treatment was varied and did not seem to influence the progress of the malady. Immersion continually or intermittently in boric baths was thoroughly tried, nor was arsenic neglected. If credit be given to any remedy, then anti-streptococcic serum should be selected.

Here, then, is a condition, lasting for some three months, beginning on vaginal mucous membrane, fungating in places, and progressing towards a fatal termination. Taking these facts into consideration, and the history as already stated, it seems justifiable to classify it as a true Pemphigus vegetans. It may be stated that syphilis was emphatically denied.

J. M. Winfield (1) has collected and arranged the previously published cases; in 1906 these numbered some fifty-eight. Dr. Colcott Fox has obtained copies of these papers, and through his kindness I have been able to see them, but as Dr. Winfield has so completely dealt with their clinical aspect nothing further will be said here on that part.

With regard to the bacteriology, some points of interest arise in the above recorded case. On three occasions a bacteriological examination of the blister fluid was made. On July 18th Dr. Bernstein reported a pure culture of a streptococcus; next, on August 5th, a mixed culture was obtained, the vesicles containing not only streptococci, but also a Gram-negative bacillus and other cocci. Finally, on October 9th, no growth of micro-organisms was obtained.

Of the above findings the first is perhaps the most important, for a pure streptococcal infection is rarely the result of accidental contamination, so one is inclined to look on it as of some ætiological signifi-

cance, and this view is strengthened when one considers the mode of onset. There was a recent confinement, a purulent vaginal discharge, and the condition originated in the vagina. Such a chain of events is suggestive.

The previous findings are by no means in harmony. Thus Waelsch (2), Stanziale (3), and Hamburger and Rubel (4) found a diphtheroid bacillus; Winfield (1) and Pernet (5) isolated *B. pyocyaneus*; Hyde (6) in his case cultivated a bacillus and a coccus, which are not classified; Gastou (7) a streptococcus and a bacillus; Marianelli (8) *Staphylococcus pyogenes aureus.*

That a streptococcus can produce a bullous lesion is demonstrated in some varieties of erysipelas. Further, as Dr. Radcliffe-Crocker (9) has pointed out, fungating papillary growths are apt to form on all chronic suppurating surfaces.

If one regards Pemphigus vegetans as a clinical entity the question still remains why in this particular disease the special characters are developed. It cannot be explained entirely on bacteriological grounds, for in other bullous conditions the result of an infective process the specific chain of happenings does not occur. Some other factor, perhaps even the causative factor, still remains to be found.

The post-mortem examination was performed forty-six hours after death by Dr. Bernstein. Emaciation was marked; a universal eruption, mostly covered over with ointment and discharges, was present. In a few places some bullæ and vesicles were seen.

No abnormalities were noted in the thoracic contents or abdominal viscera; the liver was a little pale and fatty-looking, but did not give the lardaceous reaction. A small ovarian cyst was present.

The spleen was small and not friable. Culture media inoculated from it remained sterile.

The uterus showed a multiparous cavity, with somewhat hæmorrhagic mucosa. No abscesses were found anywhere, death being apparently due to toxæmia.

I must express my thanks to Dr. Colcott Fox, Dr. R. G. Hebb, and Dr. J. J. Pringle for much assistance and advice.

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GRANULOMA ANNULARE.*

By E. GRAHAM LITTLE, M.D., F.R.C.P.,
Physician to the Skin Department, St. Mary's Hospital.

(*Continued from page* 257.)

XXXVII. Galewsky's case, *Iconographia Dermatologica* (Fasc. iii, with coloured plate).

The patient, seen in autumn, 1904, was a female servant, aged 26 years, and had had the condition for several months, during which she had been treated by a general practitioner without success. The eruption had commenced with small round red spots, which by degrees developed into nodules, and these again into rings. When seen by the author, there were small lentil-sized spots on the forearm and two rather large ring-shaped patches on the right index finger. The "spots" on the forearm were a vivid red at the edge, and, in the middle of the papule, of the colour and sheen of ivory. The two ring-shaped patches on the right index formed half-circular rings which were open on one side, indolent and of a hard, keloid-like consistence. From this red infiltration the ivory-white, shiny, hard, raised, keloid-like edge stood out conspicuously. These swellings were comparatively superficially placed and could be easily moved over the underlying tissues. The central portion of the crescents seemed quite normal, showing at the most a slight atrophic shininess. The condition disappeared slowly under treatment with arsenic (Fowler's solution) and local application of tar-lotion and plaster without any pigmentation. In July, 1905, the patient came again with a recurrence of the affection and remained under treatment for six months. The small reddish nodules with waxy, ivory-like surface appeared on the fore-arm, and on the right index thin half circles exactly similar to the earlier lesions. The patient did not react to tuberculin, and showed no symptoms of tuberculosis. The lesions were treated with salicylic soap and thiosinamine plaster, and the nodules gradually and slowly disappeared, with no other trace save slight whitish atrophic patches.

Microscopical examination showed a normal epidermis, with no changes in the

* Paper read at the Dermatological Section of the Royal Society of Medicine on June 18th, 1908.

sweat or sebaceous glands. There was a diffuse infiltration of cells in the cutis which appeared to be fixed connective-tissue cells, with very few mast cells, and in one preparation some foreign-body giant cells. This cell infiltration was in the pars reticularis, the papillary body and the subcutaneous connective tissue being entirely free. In the peripheral part of the tumour there were vascular connective-tissue strands between which round cell infiltration was seen in some places.

There were no obvious changes in the connective tissues or elastic fibres; in the central part the nuclei did not stain, and in the midst of the infiltrated patches there was necrosis.

XXXVIII. Dr. Dawson's case (from notes taken by the present writer at the meeting), Dermatological Section, March 19th, 1908.

Male, aged about 22 years. In good general health. No tuberculous history.

On left hand, in the web of the fingers of the middle and index, and the back of the hand in contiguity there were some few circinate lesions, half an inch wide, made up of whitish firm papules forming incomplete rings; very little elevated above the general level, and apparently umbilicated in the centre in some instances. On the distal phalanx of the index of the same hand there was a single, whitish, raised nodule, of more recent development with vivid red areola. The patient said that *all* the lesions commenced in this manner. They were entirely painless, and the disease persisted for seven years. No other eruption had been present at any time.

"Microscopic examination disclosed swelling of the cells of the stratum mucosum, and marked enlargement of the sweat glands and ducts" (note by Dr. Dawson).

XXXIX.—MacLeod's case (from rough notes communicated by Dr. J. M. H. MacLeod).

The patient was a man, aged 43 years. He was seen first in January, 1907, with a ringed and nodular eruption apparently restricted to the back of the left hand. The lesions had commenced fourteen days previously and had gradually increased by peripheral extension. Dr. MacLeod made the diagnosis of Granuloma annulare. He was put on pot. iod. internally, and mercurial ointment, and the lesion disappeared in about fourteen days. The rings were yellowish pink in appearance. The mucosa was unaffected. The patient came again exactly a year later with lesions similar to those described but more numerous, on the back of both hands, from quarter to half an inch in size. They were pinkish in colour, rather more rounded on the top than Lichen planus, but angular in outline. The circular lesions were due to peripheral extension. There was no itching, and no affection of mucosæ. The lesion felt hard, like Lichen planus, and Lichen planus annularis was suggested as a diagnosis.

He was put on mist. gent. acid., as he complained of indigestion; no local treatment was adopted, and the lesions disappeared a week later. No biopsy was obtainable.

[The appearance of the lesions, as shown in the photograph (Fig. 15) and the absence of chronicity seem rather to confirm the later diagnosis of Lichen planus. —E. G. L.]

Fig. 15.—Dr. Macleod's Case.

To Illustrate Dr. Graham Little's Paper on Granuloma annulare.

FIG. 16.

(From photograph lent by Drs. Hyde, Montgomery, and Ormsby.)
Case clinically regarded as granuloma annulare; histologically as keloid.
(Section lent by Dr. Ormsby.)

TO ILLUSTRATE DR. GRAHAM LITTLE'S PAPER ON GRANULOMA ANNULARE.

FIG. 17.—DR. FOX'S CASE

? Granuloma annulare (Crocker) with cyanotic extremities.
(From water-colour drawing kindly lent by Dr. Colcott Fox.)

TO ILLUSTRATE DR. GRAHAM LITTLE'S PAPER ON GRANULOMA ANNULARE.

Dr. Darier has kindly sent me notes of some very interesting cases of an uncertain type, in two of which he regarded the diagnosis of "Granuloma annulare" as probable.

XL. Case 1.—A woman, the subject of diabetes and syphilis, with a crescentic group of nodules on the thigh. Treatment resulted in mitigation of the diabetes, but persistence of the nodules. No biopsy was obtained.

XLI. Case 2.—A woman, also the subject of diabetes, with crescentic-shaped group of nodules on the hip. These also appear to have persisted.

The association of diabetes recorded in both these cases is very unusual and not paralleled by any other that I have collected.

In three other cases of eruption in the form of large raised rings, covering very extensive areas of the body, Darier's diagnosis was that of "Erythema diutinum figuratum." The biopsy in two of these showed appearances more like those of seborrhoic eczema.

XLII.—Mention has been made of a case of Hyde, Montgomery and Ormsby, referred to by Dr. Hyde (p. 252). Since this communication I have been favoured with a photograph of the case (Fig. 16) and a section of the skin prepared by Dr. Ormsby. The case was regarded clinically (*vide* Dr. Hyde's note) as Granuloma annulare; histologically it appeared to be a keloid. This keloid-like stage has been described in the histology of the case reported as Erythema elevatum diutinum (Radcliffe-Crocker and Campbell Williams), and was notable in a case of my own in an old lesion, although a recent lesion from the same case showed the features which seem characteristic of Granuloma annulare (*vide* Case XLIX). I am therefore inclined to think that the clinical diagnosis made by Drs. Hyde and Montgomery is not incompatible with the histological aspect revealed by this section, and I tentatively include this case in my list. (Compare with Cases 27 and 49, Synopsis.)

XLIII.—Dr. Colcott Fox has given me the following notes of a recent private case (Fig. 17) of his in a woman, aged about 35 years, with nodules, and rings made up of nodules, which had persisted for many years and were situated on the back of the hand. The largest ring was of the size of a shilling, and was composed of discrete, white, shiny nodules set like pearls in a brooch, in a circle. Isolated white nodules were also present on the back of the hand, and over the left index finger at the knuckle there was a lumpy flat swelling. The hands were cyanotic, with chilblain circulation. No subjective symptoms were complained of. The case was lost sight of.

My own series of cases.

XLIV. Case 1 (*Brit. Journ. Derm.*, 1905, p. 16).—Hilda M—, aged 6 years, sent to St. Mary's Hospital by the late Dr. John Garrett, of Acton, and shown at the Dermatological Society of London (December 14th, 1904). The diagnosis then adopted was that of a "ringed eruption," of the same type as Colcott Fox's cases (1895), Galloway's case (1899), and Pringle's case (No. XVI), shown at the same meeting. Its identity with Granuloma annulare, as described by Crocker, was disputed by many, adopted by some. The patient when seen at the meeting had two lesions, (1) a ringed group of papules which formed a continuous edge at first white in colour, afterwards becoming red, $\frac{1}{8}$ inch broad and raised about $\frac{1}{16}$ inch from the level of the skin. The ring was about the size of a sixpenny-piece, quite circular, and enclosing an area of skin which was redder than normal, rather more furrowed than usual, but without signs of atrophy. There was another quite similar lesion, except that it was crescentic and not an entire circle, on the skin covering the right internal malleolus. Neither lesion was attended by any subjective symptoms whatever, and these two lesions constituted the whole eruption as seen by the writer of this paper; but Dr. Garrett had recorded an attack of "urticaria," a transient eruption lasting fourteen days, and preceding the appearance of rings by some time, not definitely stated, shortly before these were noted.

The ringed lesions had persisted for four months before the case was brought to St. Mary's, and lasted about three months after this date; they finally disappeared leaving no scar or sign.

The child sweated freely, and her hands and feet were usually clammy with perspiration; the disease had commenced in August in the height of a hot summer. The family history was not obtained. The patient was a small, delicate-looking child, but without any definite illness.

Histology (Fig. 18).—There was slight thickening of the stratum corneum and the granular layer was two or three cells thick. There were large accumulations of cells, almost like the focal accumulation of tubercle, round the sweat-coils in the deeper parts of the corium and extending right into the hypoderm. The fat zone did not come into the section except in a fragmentary manner, and no definite data as to its condition were possible. The elastin was normal throughout

the section, but it was absent in the cell masses. In the central part of some of these cell-masses an appearance of destruction, or at least of feeble staining of the mass, was noted. The cells consisted chiefly of connective-tissue corpuscles with mononuclear and epithelioid

Fig. 18 (drawn with camera lucida).—Hilda M—. (Leitz objective 3; ocular 2.) *a*. Sweat-coils and ducts with infiltration. *b*. Thickened vessels in fat lobules with infiltration. *c*. Infiltration round vessel. *d*. Area of destruction of tissue. Stained with polychrome methylene blue.

cells. In the hypoderm the larger vessels appeared thickened and were surrounded in places with cells of the type described.

XLV. Case 2 (unpublished).—East London Hospital for Children. Ephraim W—, aged about 3 years, came with a single lesion, a circinate patch on the front of the left wrist. The ring was oval, with a firm, almost cartilaginous edge, whiter than the surrounding skin, and raised about $\frac{1}{16}$ in. from its level. When seen the patch was of the size of a sixpenny-piece, and was said to be enlarging. It had persisted for three months. The central portion of skin was pinker than normal, a little wrinkled, but with no definite atrophy. There were no subjective symptoms whatever in connection with it.

The child seemed fairly well; he had some remains of impetigo on the buttocks.

A request to perform a biopsy on this case frightened the mother to such a degree that the child was not seen again, and no answer was returned to letters inviting her to attend the hospital, so that the subsequent history was lost.

XLVI. Case 3.—St. Mary's Hospital. A young girl, Ellen P—, aged 16 years, shown at the Dermatological Society of London in April, 1906. The patient had come to St. Mary's Hospital a week previously to being shown with a ringed and papular eruption on the dorsum and side of the right hand. The papules were somewhat itchy, white at their commencement, becoming red later, and forming ring-shaped patches with rather indefinite outlines. An ointment of glycerine of sub-acetate of lead applied on lint with the part bandaged over had reduced the lesion to vanishing point at the time of showing the case. The nature of this case is perhaps doubtful; the localisation and clinical aspect of the lesions strongly suggested the diagnosis of Granuloma annulare; the rapid involution of the lesion is paralleled by an experience in the case of William S— (*vide* below), in whom a bandage applied after a biopsy had produced the almost complete disappearance of the nodules included in the bandage within a week, and in the case of Adamson recorded above.

XLVII. Case 4.—St. Mary's Hospital. William S—, aged 42 years. He is a "handyman" at a little "private hotel," and is a small, thin, anæmic-looking person, but with no definite illness. He is probably overworked and underfed. He perspires extremely freely and easily, and his skin is usually clammy or wet. Three types of lesion are demonstrable:

(1) An early nodule, usually waxy white and almost translucent, which becomes redder later.

(2) Rings and crescentic-shaped groups of nodules, these being discrete or running together to form a continuous edge, the central portion of the skin so enclosed being dusky in colour, smooth, and showing no signs of scarring.

(3) Doughy, circumscribed, violaceous, pad-like patches with uniform elevation and roughly circinate outline, imparting a feelin

of irregularity of surface, comparable to the surface of a Lilliputian worn flock mattress. These patches are possibly made up of deep-seated, confluent nodules, but there is no ringed edge or depressed centre, and individual papules cannot be made out.

The present distribution of the lesions, which have continued to come out from time to time during his attendance of many months at St. Mary's Hospital, is as follows:

On the front of both wrists.—The disease is said to have commenced in this position three years ago, and the lesions here are whitish warty nodules, very numerous, and tending to form roughly circinate groups, the area covered being about 2 in. by $2\frac{1}{2}$ in. Near the olecranon process there is another definitely circinate patch of a fortnight's duration. There is another circinate patch at the base of the dorsal surface of the index of the left hand, about $\frac{1}{2}$ in. to 1 in. in diameter; there are two patches on the external (radial) surface of this hand near the base of the fifth finger. There is a similar circinate, doughy patch on the dorsal surface of the right hand near the base of the fifth finger, and another patch on the radial edge of the proximal phalanx of the right ring finger, circinate patches on the dorsal surface of the middle phalanx of the middle finger and of the index.

The patches on the fingers are said to have been of recent origin, having appeared within the last nine months.

There was a small patch on the extensor surface of the left forearm (excised for histological examination).

There is a large circinate patch $1\frac{1}{2}$ in. across over the right patella.

The colour of the enclosed ring is a pale to a bluish-pink; the surface is perhaps a little wrinkled or striated, but not shiny or presenting signs of atrophy. The man sweats extremely freely, so that he has to change his garments sometimes three times a day. He is anæmic, almost cachectic-looking, and thin, but with no definitely tuberculous symptoms.

Fresh papules appeared in the case from time to time during some months that he was under observation; then a small grouped patch came out on front of the right elbow. These new papules were pale, almost colourless, and of the size of a split-pea.

There were no buccal lesions and no symptoms pointing to Lichen planus.

The disease slowly disappeared with local treatment (salicylic acid, zinc ointment, and carbolic acid).

The patient was shown at the Dermatological Society of London (*Brit. Journ. Derm.*, 1906, p. 117), and the diagnosis of Granuloma annulare was generally accepted.

Histology (Fig. 19).—The epidermis is not in any way altered; there is no acanthosis; the granular layer is about two cells thick; the rete normal.

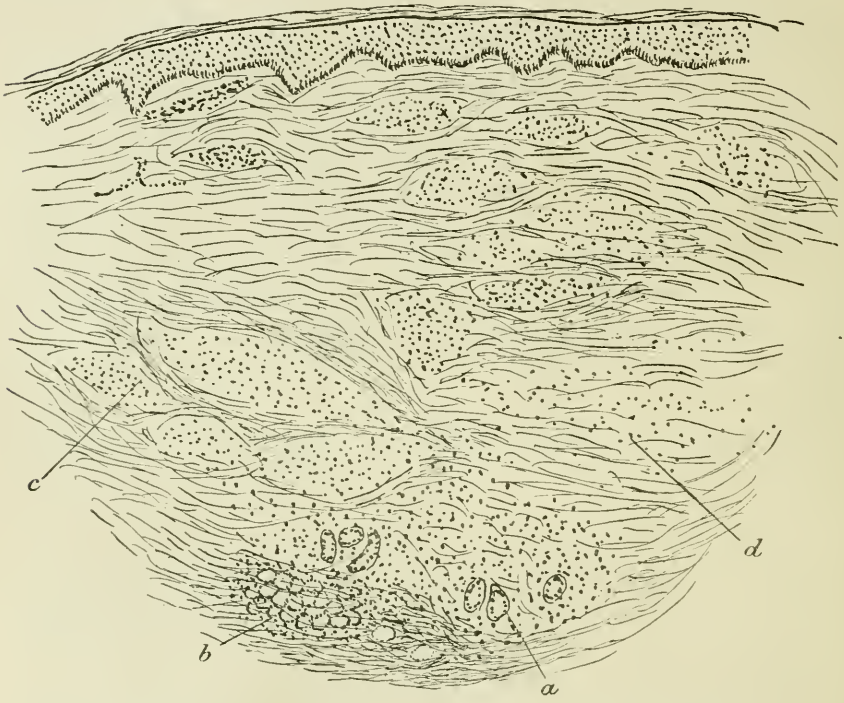

Fig. 19 (drawn with camera lucida).—William S—. (Leitz objective 3; ocular 2.) *a*. Sweat-coils surrounded by cells. *b*. Fat lobules infiltrated by cells. *c*. Clump of cells, walled in by collagen. *d*. Diffuse infiltration with breaking up of collagen. Section stained with Hausen-v. Giéson.

The main changes affect the deeper layers of the corium and hypoderm. There is a dense cell infiltration in the zone of the fat lobules, and some of these have undergone fibrotic organisation, spaces corresponding to fat cells being left here and there in the organised mass. The sweat-glands and ducts, the hair-shaft, and

the vessels are surrounded by dense cell infiltration. The vessels, especially in the hypoderm, are thickened, and in some cases their lumen obliterated. In the lower parts of the corium the collagen and elastin bundles are disintegrated, the cellular mass being interspersed by fragments of connective and elastic tissue. In other parts of the section, especially in the upper zones, the cell masses are, as it were, encapsuled by collagen and elastin, nodular foci being thus formed. In many cases it is possible to identify portions of sweat-ducts or vessels in the nodule, which seems thus to serve as a centre for the infiltration.

The cell infiltration consists of large mononuclear cells, staining deeply with nuclear stains; and of connective-tissue corpuscles, staining less deeply; and large epithelioid cells. Mast cells do not appear especially numerous, and no giant cells or typical tuberculous "nodules" are discernible. No micro-organisms were seen in the few specimens specially stained for these.

XLVIII. Case 5.—East London Hospital for Children. Ethel C—, aged 4 years, sent to the Children's Hospital, Shadwell, by Dr. Fiddes of Forest Gate. This case was shown at the meeting of the Dermatological Section of the Royal Society of Medicine (February 20th, 1908), and was generally accepted as an instance of "Lichen annularis" (*vide* discussion, *Brit. Journ. Derm.*, March, 1908).

The eruption consisted of two lesions, one a group of pearly whitish nodules, arranged in a complete circle $\frac{1}{2} \times \frac{3}{4}$ in. with a pink areola and situated below the left buttock, in the sulcus between the buttock and thigh; the other was a single nodule in a corresponding position on the right buttock, the size of a pea, deep seated and bluish in colour. From this nodule the sections to be described were obtained.

The circinate lesion had persisted for about three months. It was best seen when the skin on which it was placed was stretched, when the nodules stood out as discrete white swellings $\frac{1}{10}$ in. in diameter and rather less than that in height. The enclosed skin was a darker colour than normal—slightly violaceous and wrinkled. Both lesions were quite painless, and the child was unconscious of their presence. No other had appeared at any time.

The patient herself was a fine healthy girl, fat, rosy, and well in

every way. But the family history was markedly tuberculous, a brother of the child being at present in the Children's Hospital with tuberculous knee, and one paternal uncle having died of phthisis at the age of thirty-four.

The position of this eruption on the buttocks was paralleled by Fox's and Adamson's cases. The single remaining lesion, the ring of nodules, had quite disappeared five months after she first came, the treatment being salicylic acid plasters (10 per cent.) changed three

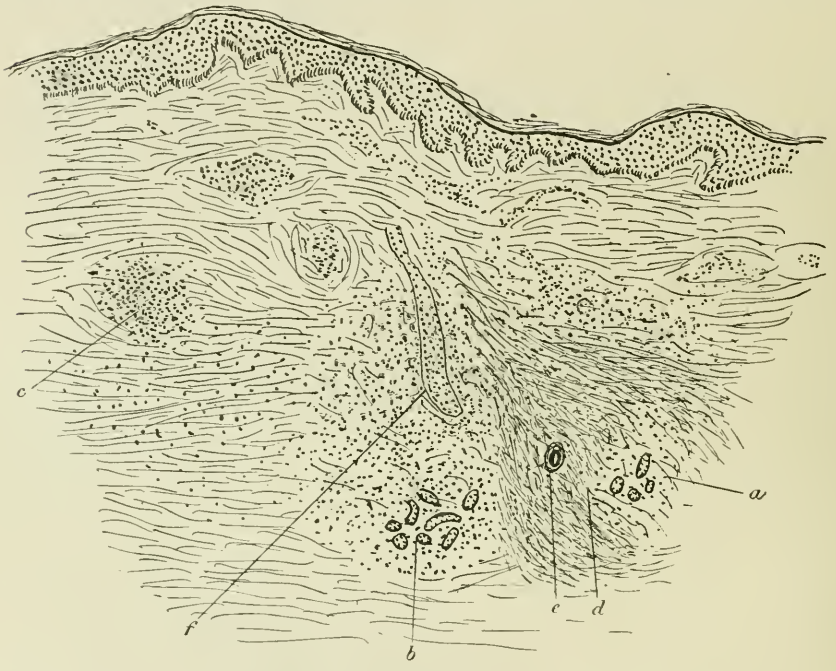

FIG. 20 (drawn with camera lucida).—Ethel C. (Leitz objective 3; ocular 2.) *a*. Sweat-coils, surrounded by cells, and lying in broken-up collagen. *b*. Sweat-coils, centre of a nodule. *c*. Clumps of cells walled in by collagen. *d*. Area of necrosis. *e*. Thickened blood-vessel. Section stained with Hausen-v. Giéson.

weeks later, because of the pain they caused, to salicylic acid ointment with five grains of ichthyol to the ounce.

Histology (Fig. 20).—The isolated nodule from the left buttock was excised, hardened in alcohol and cut in paraffin. The section showed a normal epidermis with no thickening of the rete. In the corium there were clumps of cells aggregated together, and walled in by connective tissue; and rows of cells running up apparently from the

deeper to the superficial skin along the line of sweat-ducts, vessels and hair-shafts. These cell collections were composed of mononuclears, connective-tissue cells, a few epithelioid cells, and rather numerous mast cells. The elastic fibres were absent in the cell masses. There was a nodular area of necrosis in the connective tissue in the deepest part of the corium.

XLIX. Case 6.—St. Mary's Hospital. Ada C—, aged 18 years. A florid-complexioned girl, with the "faux embonpoint" of the tuberculous, came to St. Mary's Hospital on January 8th, 1908, with a number of small, deep-seated nodules, about to be described. The family history was unimportant, and she herself complained of no illness, but she was detected subsequently by Dr. Sidney Phillips, who kindly examined her for me, to be suffering from early pulmonary tuberculosis at one apex. She is a Londoner, and a laundress by occupation.

Description of lesions.—These are of three types:

(1) An early white papule, like boiled sago grain.

(2) A bluish, deep-seated nodule, firm to the touch, and in the substance of the skin and movable with it.

(3) Dough-like, and in some places keloid-like, masses, probably composed of individual nodules, forming raised, infiltrated patches on the fingers, the arm, and the breast. In some cases, *e.g.* at the wrist, there is an incomplete ring in the shape of an umbilicated large nodule, and some three or four of these are grouped in an irregular crescent. With this exception the lesions are for the most part isolated.

All the lesions are painless, not tender on pressure, and with no subjective symptoms associated with them.

Distribution: Right hand.—There is an infiltrated patch composed apparently of several nodules, on the proximal phalanx of the little finger. This patch at first was a doughy infiltration; it resolved itself later into separate nodules which became umbilicated; there is also a circinate patch with a central depression and surrounded by a red areola, the edge raised, and of a diameter of $\frac{1}{4}$ in. on the dorsal surface of the right hand half an inch from the metacarpo-phalangeal joint.

On the ulnar edge of the right forearm, 1 in. above the ulnar

prominence, there is a group of five circinate lesions with a central depression, puckered but without actual ulceration. The foci form a crescent of about 1 in. diameter, each lesion being about $\frac{1}{4}$ in. across.

On the middle of the forearm, extensor aspect, there is a single depressed pitted scar, about $\frac{1}{4}$ in. in diameter, with some blue staining and reddening around it, the remains of a previous lesion. There is a similar depressed reddened scar on the inner aspect of the forearm, near the olecranon process.

On the extensor aspect of the upper arm there was a deep-seated bluish recent nodule, which was excised for examination. The wound healed with keloid-like scar.

On the inner aspect of the right upper arm there was a prominent purplish-blue, deep-seated, keloid-like swelling, which was also excised for examination; this was one of the oldest lesions; two quite similar lesions of the same date were found on the skin just above the prominence of the right breast. There is a white nodule surrounded by a vivid violaceous areola on the point of the chin. There is an isolated, deep-seated, blue nodule on the left side of the back, about one inch below and internal to the angle of the scapula.

Left hand.—On the proximal phalanx of the middle finger there is a deep-seated, hard nodule which can be felt easily in the substance of the skin, but not readily seen. There are two bluish nodules with depressed centres at the base of index (dorsal aspect). There is a pitted scar on the radial edge of the forearm two inches below the point of the elbow. There is a deep-seated blue nodule one inch below the olecranon process and another on the point of the shoulder above the vaccination marks.

Right foot.—There is a nodule with central atrophy at the base of the little toe; near this, on the dorsal aspect of the foot, are four grouped, white, sago-like nodules, all of recent development. There is a deep-seated blue nodule, half an inch external to the border of the tendo Achillis, about two inches above the level of the malleolus.

Left foot.—There is a single nodule on the dorsum of the foot, at the base of the little toe.

There is a patch of infiltration, bluish-red, with two small elevations, with pitted centre, and one unpitted white nodule over the tibio-astragaloid articulation, front aspect.

There is a group of nodules on an infiltrated patch over the prominence of the tendo Achillis, 1 in. above its insertion.

The abdomen is free.

There is a group of pigmented patches (remains of old nodules?) over the sacrum.

There is a bluish nodule and a scar, the remains of an older lesion, on the posterior surface of the right thigh, at the level of the gluteal fold.

There is a small blue nodule in the middle of the right buttock and another close to the internatal fold. There is a blue nodule in the middle of the left buttock.

There are one or two small depressed scars on the forehead, and one on the left cheek.

The scalp appears quite free.

There are no glandular enlargements; no hyperidrosis; no night sweating.

While under observation several of the nodules involuted, leaving shallow pitted scars in many instances; in others, no trace.

The patient was tested with a ·5 per cent. solution of Calmette's tuberculin dropped into the left eye (the conjunctiva). A doubtful reaction followed, the conjuctiva being very slightly reddened. Ten days later, a 1 per cent. solution of Calmette's tuberculin was used, producing a violent conjunctivitis within twelve hours. The opsonic index had been estimated on several occasions, as shown in following table:

Before admission to St. Mary's Hospital 1·02 (date some time in January).

After admission	February 5th, 1908	·97
,, ,,	,, 7th, ,,	1·45
Ten minutes after "Calmette"	,, 10th, ,,	·87
Six hours after "Calmette"	,, 10th, ,,	·84
Twenty-four hours after "Calmette"	,, 11th, ,,	1·03
	,, 12th, ,,	1·15
	,, 13th, ,,	1·03
	,, 14th, ,,	·91

I am much indebted to Dr. Colebrook for these estimations.

A recent nodule from the back was excised, and the tissue introduced into a guinea-pig, under the direction of Sir A. E. Wright by

his assistant, Dr. A. Fleming. The test animal was killed three months later, and showed no symptoms of tuberculosis.

Histology.—Two nodules were excised in this case. The first, which had persisted for five months, was situated upon the upper arm, and was a prominent, purplish-blue, keloid-like tumour. This had never ulcerated, and similar lesions had, according to the patient, left the pitted scars which were to be seen on the arm and elsewhere. The section showed the whole of the central part of the tumour, from the epidermis to the hypoderm occupied by thin strands of faintly-staining fibres, in horizontal wavy bands, contrasting with the normally thick and normally stained connective tissue at the periphery of the swelling. Interspersed between these fibres were very numerous groups of cells encapsuled by the connective tissue. Elastin was entirely absent in this part of the tumour, although present at the periphery. The epidermal down-growths were also conspicuously absent, the line of junction of corium and epidermis being, as in scar tissue and keloid, an unbroken horizontal plane, without papillary bodies or hair-follicles. The resemblances of this section to keloid make me inclined to think that in certain stages of Granuloma annulare the clinical and histological features of keloid may be closely imitated. I am confirmed in this view by the experience of Drs. Nevins-Hyde, Montgomery, and Ormsby with a case which is alluded to in the description of Dr. Montgomery's case of ringed eruption recorded elsewhere in this paper. These observers met with a case which, clinically, they would have regarded as an instance of "Granuloma annulare" had not the histology been that of "circinate keloid." The photograph of this case, kindly sent to me by these good friends of mine, together with a section of the case by Dr. Ormsby, recall very closely the appearances seen in the nodule I am here describing. Further confirmation is given by the case of Quinquaud, the wax model of which is described in the St. Louis Museum Catalogue as "fibromes fasciculés," a description which would aptly fit the histological characters of both the present case and that of Drs. Hyde, Montgomery, and Ormsby. The frequent mention, in the synopsis of cases, of cicatricial and atrophic clinical appearances in certain stages of the lesion of Granuloma annulare supports the suggestion I would make that keloid-like stages are met with in the involution of the nodule of Granuloma annulare.

In the second nodule from the case of Ada C—, which was a quite recent lesion, also from the arm but certainly not more than one week old at the time of excision, the appearances are much more in conformity with the other cases I have recorded, and are, indeed, especially like the histological features of the cases of William S—, of my series, and the case of Brocq, sections of which are described in detail under the description of these cases. These three cases, in

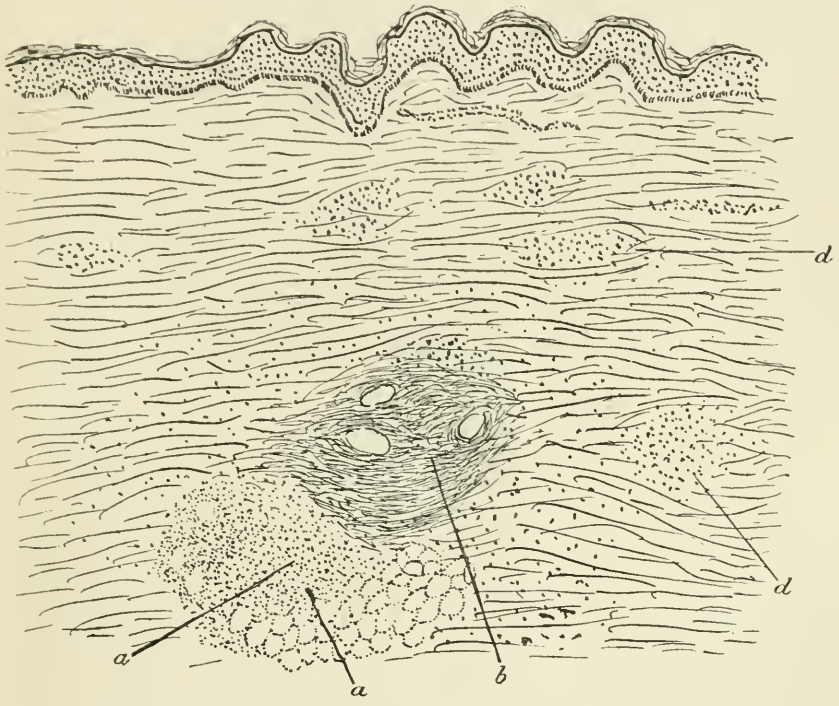

Fig. 21 (drawn with camera lucida).—Ada C—. Recent nodule. (Leitz objective 3; ocular 2.) *a*. Dense infiltration with early fibrosis of fat. *b*. Fibrosis with large spaces. *d*. Clump of cells surrounded by collagen. Stained with Hansen-v. Giéson.

fact, form a series which has materially influenced me in the view I now hold that Lichen annularis and Granuloma annulare are one disease, and with strong associations with tuberculosis. My argument is, briefly, that William S— was clinically an undoubted case of Granuloma annulare as it appears in the adult; Brocq's case apparently as undoubtedly a case of Lichen annularis in the child; and Ada C—,

though clinically a dubious instance of either, histologically is identical; and Ada C— showed definite tuberculous symptoms.

To resume the description of the second (recent) nodule in this case (Fig. 21):

The stratum corneum and granular layer are normal: there are small accumulations of cells surrounded by normal connective and elastic tissue in the cutis in its middle part, and more deeply there are areas where the elastic and fibrous tissue is slightly broken up, and infiltrated with cells. This infiltration increases in severity in the deeper layers of the skin, until in the hypoderm the whole fatty zone is impregnated with cells, and there is here definite sclerosis and fibrotic change of the fat lobules, very clearly seen in the sections stained with Hansen–v. Gieson.

The cell infiltrations in the corium, which are centred round hair-shafts, vessels and sweat-ducts, are seen to consist chiefly of large mononuclears with some polynuclears; of connective-tissue corpuscles and epithelioid cells; and in this case a considerable number of mast-cells. Some multinuclear giant cells without central caseation were seen in one section.

(*To be concluded.*)

SPOROTRICHOSIS.

A Résumé of the Literature relating to Sporotrichial Infections of the Skin.

By H. G. ADAMSON, M.D.

History.—The recognition of sporotrichial infections of the skin is of relatively recent date. The first case was reported in America by Schenk in 1898, as "refractory subcutaneous abscesses caused by a fungus possibly related to sporotricha." A similar case was published by Hektoen and Perkins, also in America, in 1900. In both these cases the infection had started in the index finger, and had led to a train of subcutaneous abscesses, connected by a chain of chronic lymphangitis, along the arm. A striking feature of these abscesses was their obstinacy to ordinary methods of surgical treat-

ment. A new form of pathogenic fungus was obtained by culture from the lesions, the *Sporothrix Schenkii*. It was not until 1906 that attention was again drawn to this affection by an important paper by de Beurmann and Gougerot in the *Annales de Dermatologie*, comprising a study of human sporotrichoses in general, of the cultural and morphological features of its parasite, and of a clinical type which these observers called the "syphiloid type." In the French cases there were multiple, widely distributed, gummatous-like lesions. De Beurmann here reported four new examples of sporotrichosis, one of which he had previously published in 1903 as a case of "multiple subcutaneous abscesses of mycosic origin." He also referred to the two American cases, and to a third by Brayton, probably of the same nature (in a florist), in which a wound of the forefinger was followed by a train of chronic abscesses along the arm. A case of Lesné and Monier-Vinard (1906), had also proved to be a sporotrichial infection, and Dor (1906), had recorded a case in which the abscesses were large and healed readily after surgical interference, but which had yielded a sporothrix. After the publication of de Beurmann and Gougerot's paper there followed a series of cases by Gaucher and Monier-Vinard, Duval and Fage, Vaquez, Laubry and Esmein, and Bonnet. During 1907 de Beurmann and Gougerot published numerous papers recording fresh cases and dealing with the clinical, histological, and cultural features of the affection. In November, 1907, these observers, in a second memoir in the *Annales de Dermatologie*, described what they called the "tuberculoid type," and gave an exhaustive study of the pathological anatomy of the lesions. In 1908 the publication of new cases in France continues, and three examples are recorded from South America. Further knowledge of the disease has shown that sporotrichosis affects not only the skin and subcutaneous tissues, but that mucous membranes may be involved, and that intra-muscular gummata and periosteal gummata (and perhaps even pulmonary abscesses) may be caused by the presence of the sporotrichium. Widal and André have isolated the parasite from the blood of a patient with cutaneous sporotrichosis.

Symptoms.—Two main clinical types of this affection have been described. First there are the American cases, in each of which the infection took place in the index finger, and was followed by a line of chronic abscesses on the arm connected by a train of chronic lym-

phangitis. It was the refractory nature of these lesions which led to their being culturally examined and to the discovery of the sporothrix.

In the second group of cases (the French cases) the lesions consisted of multiple and widely distributed abscesses, generally hypodermic, but, sometimes, associated with these, also dermic and epidermic lesions. De Beurmann describes a syphiloid type and a tuberculoid type, according as the lesions simulate syphilitic gummata or Tuberculosis verrucosa. It would seem that these modifications represent, usually, only a different stage of the lesion, but lesions primarily of Lupus verrucosus type have been described. The case with large abscesses of Dor seems to be unique.

The hypodermic lesions form cold abscesses or gummata varying in size from that of a pea to that of a small mandarin orange. Their number varies from five to twenty or thirty. They are disseminated without apparent order in the subcutaneous tissue of the limbs and trunk. The development of the nodules is insidious and painless, so that while of small volume they may be overlooked. On palpation they are hard and resistant, and sometimes lightly adherent to the subcutaneous tissues. In from two to three months they soften and become adherent to the skin, which becomes at this part red or violaceous, and eventually perforated, the contents of the swelling discharging through the fistulous opening as a greyish yellow homogeneous pus. The fistulous opening enlarges, its borders become swollen and infiltrated with new small abscesses. Eventually, as the most favourable event, the suppuration ceases, and a violaceous cheloid-like scar remains. Incision of the abscesses does not lead to more rapid healing, since the same infiltration and swelling of the borders of the wound takes place. Sometimes the lesions, instead of involuting in the manner described, undergo a further development; the orifice enlarges until it leaves an ulcerated and discharging surface, or a crusted or fungating infiltration, which may recall exactly the aspect of Tuberculosis verrucosa cutis. The lymphatic glands are generally uninvolved. It has not been clearly demonstrated that the viscera are ever infected—though this seemed probable in a case of Massary, Doury, and Monier-Vinard. In one case, which showed sporotrichium in the sputum, the lungs were sound. In other cases cutaneous sporotrichosis has occurred in association with pulmonary

tuberculosis. Most patients, however, have been in good health except for the skin-lesions.

Recently, as already indicated, cases have been lately recorded in which gummata were present also beneath the periosteum. These cases have all been tibial periostitis, generally in association with subcutaneous gummata, but, in one case, alone. Intra-muscular abscesses have also been met with.

Sporotrichosis of mucous membranes.—De Beurmann and Gougerot, Brodier and Gaston, and Letulle have recorded mucous membrane lesions. In Letulle's case the mucous membrane of the whole bucco-laryngeal cavity was uniformly involved in a vast granulating ulcer, which was not, however, depressed below the surface, and which had led to no loss of tissue as in tuberculosis or in syphilis. The sporotrichium may also exist in a case of sporotrichosis in the bucco-pharynx and in the larynx in a saphrophytic state, *i. e.* without causing lesions.

The fungus.—*Sporotrichium Beurmanni* (the *Sporotrichium Schenkii* is probably a different variety). The presence of the fungus is only rarely and with difficulty demonstrated in the lesions, but when found it is seen as short or oblong rods, 2–5 μ × 1–3 μ, granular, basophilic, then acidophilic (degeneration stage), surrounded by an uncoloured areola. The fungus may be free or in phagocytes. On the other hand, cultures are readily obtained on most of the usual media. The most suitable medium is Sabouraud's peptone-glucose-agar (peptone Chassaing 1, glucose brute 3·7, agar 1·5, water 100). The fungus is best grown at room temperature and with the tubes not capped. Colonies appear on the fourth to sixth day as small white acuminate points 1 mm. in diameter, surrounded by a white areola finely rayed. They slowly increase in size and become convoluted and brown in colour.

Films from cultures show long filaments, 2 μ broad, together with numerous ovoid spores 5–6 μ in length by 3–4 μ broad. Here and there single spores or bunches of three to thirty are seen attached to the mycelial filament by a short pedicle.

Saprophytism of Sporotrichium Beurmanni. — The saprophytic nature of the fungus has been demonstrated by its culture upon various animal structures (caterpillars, flies, larvæ, etc.) and upon vegetables (lettuce leaves, etc.), and it has been suggested that infection may take place by contact with unclean vegetables, or from the same source by the alimentary canal.

Experimental sporotrichosis in animals.—De Beurmann produced a generalised subcutaneous gummatous sporotrichosis in a new-born guinea-pig by feeding it upon milk containing the parasite. And sporotrichosis has been reproduced in the cat, the mouse, the monkey, and the rat by subcutaneous or by intra-peritoneal inoculation. The guinea-pig is the least susceptible animal, the results of inoculation being nearly always negative. In the cat, the monkey, and the mouse the results are more often positive but inconstant. The rat is very highly susceptible. De Beurmann has made a complete study of artificial sporotrichosis in the rat, which confirms all his anatomo-pathological observations in human sporotrichosis, and adds a whole series of visceral reactions as yet unknown in human beings—hepatitis, pneumonia, arthritis, nephritis, etc. The parasite is found in great abundance in the lesions of rat sporotrichosis both in the giant-cells and in the other types of lesions.

Spontaneous animal sporotrichosis.—Lutz and Splendore of Brazil have described a spontaneous sporotrichosis in the rat due to *Sporotrichium Beurmanni.* Sporotrichosis has also been observed in the mule (Fonteynot and Carongean in Madagascar [unpublished case]), and in the dog (Gougerot and Caraven,—in three puppies in one litter). These facts have suggested the possibility of the origin of the disease in man by contagion from animals.

Pathological anatomy.—As clinically, so histologically, the lesions present sometimes the characters of tuberculosis, sometimes those of syphilis. De Beurmann and Gougerot have made a very exhaustive study of the pathological anatomy of the lesions, and their papers are illustrated with many reproductions of microscopical details. The lesions present three types of reaction in combination, namely: (1) a lympho-connective tissue or syphiloid reaction; (2) an epithelioid (with giant cells) or tuberculoid reaction; and (3) a polynuclear or ecthymatiform.

Diagnosis.—In making a diagnosis the main points to observe are: multiplicity of lesions, indolence, slow involution, firm consistence, viscid grey-yellow homogeneous pus, swollen margins with central fistulous opening into the cavity, generally absence of enlarged glands, good general health. The crateriform character of the lesions is especially characteristic. In those cases where the base of the exposed cavity is crusted or vegetating, simulating cutaneous tuber-

culosis, sporotrichosis is suspected from the central softening of the lesions, and from the occurrence of the more typical gummata elsewhere. Sporotrichiosis must be considered, too, in the presence of gummatous periosteal swellings and chronic intra-muscular abscesses. The diagnosis is readily confirmed by cultural methods, remembering the importance of using suitable media and of not capping, and of incubating at ordinary room temperature. De Beurmann has shown that an early orchitis in the rat after inoculation with suspected products is diagnostic of sporotrichial infection. Sporotrichosis is not incompatible with the presence of syphilis or of tuberculosis.

Treatment.—It is characteristic of the lesions that they are remarkably obstinate to the ordinary surgical methods of treatment. Under the administration of iodides they rapidly disappear.

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CURRENT LITERATURE.

THREE CASES OF THE RINGWORM OF THE CALF TRANSMITTED TO MAN. Mabel Purefoy Fitzgerald. (*Journ. of Path. and Bact.*, January, 1908.)

The authoress studied three cases of suppurative agminated folliculitis, two in men attending calves with ringworm, and one in a boy who played under trees where infected calves rubbed. In Case 1 the side of the hand was affected; in Case 2 the scalp showed a parent and secondary patches; in Case 3 the neck, beard region and scalp were the seat of closely aggregated multiple lesions. Cultures were obtained on beer wort agar and Sabouraud's proof medium at a temperature of 22° C. In the two first cases the cultures were identified as *Trichophyton gypseum* (Sabouraud), which was originally isolated from the horse. The cultures were examined by dissociation in glacial acetic acid or 25 per cent. of glycerine, and permanent preparation of films made with a drop of sterilised

salt solution, dried, fixed by heat, and stained with a 1 per cent. watery methylene blue. In Cases 1 and 2 three organs of fructification were found, viz. long spindle-shaped multilocular bodies, conidia, some sessile, mostly with sterigmata growing on the end or sides of hyphæ or its branches, gradually forming grape clusters; chlamydospores which were constant in old cultures. There were also spirally twisted hyphæ or hyphal branches in some cultures, which Matruchot and Daisonville suggested in their researches (1899) tended to prove the trichophyta they worked at were ascomycetes.

The parasite in Case 3 was an ectothrix of uncertain nature, forming a yellow-grey culture which became dark greenish-yellow and finally black. The culture was humid and slimy. Bodin, to whom the fungus was submitted, thought it possibly a member of the *Sporotrichium Beurmanni* group.

The authoress does not specially mention a plastery general aspect of the first cultures, which Sabouraud says is characteristic of *T. gypseum* on all media. It is curious how little these calf ringworms have been studied considering their extreme frequency. Sabouraud describes a yellow vermicular culture which he suspected to be of calf origin, and Bunch obtained from an inflamed pustular eruption in the beard, contracted from a calf, a finer-patterned culture than a calf ectothrix.

T. C. F.

AN EXPERIMENTAL INVESTIGATION OF INFECTIVE SARCOMA OF THE DOG, WITH A CONSIDERATION OF ITS RELATIONSHIP TO CANCER. Henry Wade. (*Journ. of Path. and Bact.*, January, 1908.)

Although this disease occurs only in dogs, the investigation may not be without interest to dermatologists. It is not uncommon, and has a world-wide distribution. It is a contagious venereal disease, the transmission of which occurs during coitus. Thereafter there develop on the genital tract of the animal infected soft, fleshy, highly vascular tumours, having to the naked eye an appearance similar to a rapidly-growing sarcoma and a histological structure identical with that of an alveolar sarcoma. After an exhaustive study, including inoculations, the author concludes:

That infective sarcoma is a general disease characterised by the production of a local lesion possessing the histological structure of an alveolar sarcoma. That it is caused by an intra-cellular virus conveyed by contagion from a living cell to a living cell. That the tumours formed after natural infection probably consist of cells derived entirely from the tissues of the host. That the nature of the virus cannot be detected, and (*a*) cannot be revealed by any method of staining; (*b*) does not pass through a Berkefeld filter; (*c*) is probably not an ultra-microscopical micro-organism; (*d*) cannot be isolated apart from the tumour; (*e*) is not a spirochæte. That the disease can be reproduced readily by subcutaneous inoculation into animals of the same species and into the fox. A capsule is gradually formed around the tumour, and the latter disappears by gradual cytolysis associated with the presence of, and probably caused by, lymphocytes and polyblasts. Immunity follows spontaneous recovery. The growth of the tumour is accompanied by a gradual increase in the number of mononucleated cells in the circulation, and with the development of a toxin.

T. C. F.

NOTE ON A PALLIATIVE TREATMENT OF ELEPHANTIASIS.

Aldo Castellani. (*Journ. Cut. Dis.*, May, 1908.)

The author records five cases in which marked improvement followed the injection of *fibrolysin* (Merck), which is a water-soluble combination of thiosinamine with sodium salicylate, and can be obtained in sterile glass ampullæ, each containing 2 c.c. of liquid—corresponding to 0·2 gr. of thiosinamine.

His method of treatment is as follows: The patient is rested for a week in bed with the diseased parts bandaged with flannel or india-rubber, and the part is massaged twice daily, which softens the parts. Injections, which are almost painless, of 2 c.c. of fibrolysin are made daily or every other day in various parts of the affected regions, with antiseptic precautions, by an antitoxin syringe supplied with a strong needle. The point of injection is covered with a sterile pad of gauze and the part firmly bandaged.

After about a month the injections are stopped for a week and india-rubber bandages applied, under which the verrucose-like projections subside. After a week or ten days a second course of thirty or more injections is given; then again a week's rest with rubber bandaging, followed, when necessary, by another course of injections. Finally, a regular wearing of putties or elastic stockings is ordered. To remove the superfluous skin remaining after most of the subcutaneous tissue has been absorbed, Castellani suggests the excision of long elliptical strips of skin.

T. C. F.

CULTURE MEDIA FOR DERMATOPHYTIC FUNGI: TECHNIQUE OF MANUFACTURE OF MEDIA CONTAINING SACCHARINE AGAR-AGAR, CALLED "TEST MEDIA." Sabouraud. (*Ann. de Derm. et de Syph.*, February, 1908, p. 99.)

A vessel of five litres' capacity is taken and into it are poured three litres of pure, not distilled, water, to which are immediately added 54 grammes of agar cut into small pieces, 30 grammes of granulated peptone of Chassaing, 120 grammes of selected sugar (to be obtained from Cogit, 36 Boul. St. Michel, Paris).

The vessel is corked with wool and is introduced into the autoclave and heated gradually until a temperature of 120° is reached. The mixture is cooled to 100° and then rapidly filtered through Chardin filter-paper into the desired receptacles. These are corked with wool and again heated in the autoclave to a temperature of 120°, the gas being immediately extinguished on the thermometer marking this temperature.

E. G. L.

MYCOSIS FUNGOIDES OF FOUR YEARS' DURATION, WITH LEUCOCYTOSIS AND PREPONDERANCE OF MONONUCLEAR AND EOSINOPHILE CELLS; TERMINAL ANASARCA; A MYCOSIC NODULE IN THE RIGHT LUNG. Lenoble. (*Ann. de Derm. et de Syph.*, June, 1908, p. 348.)

The case which forms the basis of the paper was observed from the period of the præmycosic eruption to the fatal end, with tumour formation, and is very com-

pletely reported; the main features of interest are indicated in the comprehensive title adopted. X-ray treatment doses not appear to have been tried.

E. G. L.

IDENTIFICATION OF THE MICROSPORUM LANOSUM (SABOURAUD, 1907) WITH THE MICROSPORUM CANINUM (BODIN AND ALNEY, 1897). SABOURAUD. (*Ann. de Derm. et de Syph.*, March, 1908, p. 153.)

SABOURAUD, deceived by the pleomorphism which overtakes old cultures of ringworm, and having only old cultures of Bodin's *Microsporum caninum* to compare with his fresh cultures of what appeared a new species, announced, in 1907, the appearance of a distinct species of microsporum to which he gave the name of *Microsporum lanosum*. In the interval since his paper was published he has observed the same pleomorphic forms to occur in his cultures of *M. lanosum*, and he is now convinced that he was premature in differentiating this new species, which he regards as identified completely with Bodin's older species. Since this form can occur in other animals than the dog, and is unexpectedly frequently found in human beings, the name *M. lanosum*, descriptive of its naked-eye appearance in culture, is preferable to the older term *M. caninum*.

E. G. L.

FREQUENCE OF THE MICROSPORUM CANINUM VEL LANOSUM. SABOURAUD, SUIS, AND SUFFRAN. (*Ann. de Derm. et de Syph.*, June, 1908, p. 321.)

OF seventeen cases of animal ringworm observed in Toulouse, sixteen were derived from the dog and fifteen gave cultures of *Microsporum lanosum*. This is the gist of the important paper here referred to, which adds to the information so rapidly accumulated lately on this form of fungus by Sabouraud and his school the important information of its social distribution. The clinical symptoms of tinea in the dog are minutely described and comprise four stages:

(1) Stiffening of the hair in the affected patches.

(2) Fall of the affected hairs with the matted crust which envelops them, leaving a smooth, finely pityriasic patch.

(3) Follicular inflammation of the patch, sometimes lacking.

(4) Decrease of inflammation and patches left smooth and dry.

In analysing the entries at the École Lailler, devoted to ringworm, of 115 cases of microsporum 14 gave cultures of *Microsporum lanosum*. This type of microsporum may attack the beard and adults and spread in epidemics; it is much less persistent and more easily cured by local application than *Microsporum Audouini*. The cultural characters are depicted in six figures, and the paper is further illustrated by numerous photographs.

E. G. L.

A PRELIMINARY NOTE ON THE MICROSPORUM LANOSUM OF DOGS. SUIS AND SUFFRAN. (*Ann. de Derm. et de Syph.*, March, 1908, p. 151.)

FIVE cases of *Microsporum lanosum* derived from the dog were demonstrated by these authors. These were isolated, not epidemic, occurrences, and the cultures from them were identified by Sabouraud as being the same as his

Microsporum lanosum, the animal origin of which he suspected, but the actual animal concerned was left uncertain by his paper of 1907.

E. G. L.

ON THE TREATMENT OF SYPHILIS WITH HETOL. BRÖLEMANN. (*Derm. Centralblatt*, February, 1908, p. 136.)

THE writer uses hetol both alone or with mercury. He says the spirochæte, in contra-distinction to other micro-organisms, has the peculiarity of not causing fever, and therefore no lasting leucocytosis for the protection of the body. He goes on to say that most of the other methods of treating syphilis cause a leucocytosis, *e.g.* mercury, iodide, atoxyl, and, more recently, nuclein. Mercury and iodide often fail to act, so it would seem in these cases these two alone are not sufficient to influence the spirochæte. He suggests that a leucocytosis is wanting in these cases, either because the organism is not capable of supplying the increased demand made on it, or that the mercury and iodide have no longer an exciting action on the tissues. Hetol, he says, causes a pronounced leucocytosis; he uses it in 1 per cent. to 4 per cent. solution for injection. It acts best when there is an unmixed infection. Care should be given to the dosage in order to maintain a lasting leucocytosis.

D. F.

QUARTERLY SURVEY OF DERMATOLOGICAL LITERATURE.

ERYTHEMAS AND INFLAMMATIONS, ETC.

Acne Agminata, A Case of. W. B. TRIMBLE. (*Journ. of Cut. Dis.*, July, 1908, p. 309.)

Acne Rosacea, The Treatment of. V. ZEISSL. (*Münch. med. Wochenschr.*, May 19th, 1908, p. 1071.)

Chronic Superficial Dermatitis in Circumscribed Patches, with Symmetrical Distribution occurring in Children, On a Form of. H. G. ADAMSON. (*Brit. Journ. Derm.*, April, 1908, p. 109.)

Erythrodermia Desquamativa of Children at the Breast. CARL WEINER. (*Brit. Journ. Child. Dis.*, June, 1908, p. 244.)

Furunculosis, Multiple, complicating Typhoid Fever. F. E. TYLECOTE. (*The Med. Chronicle*, May, 1908, p. 77.)

Generalised Erythrodermia with Exfoliating Dermatitis, Consecutive to a Mercurial Treatment by Pills and Frictions of Neapolitan Ointment. (*Bull. de la Soc. Méd. des Hôp.*, June 25th, 1908, p. 940.)

Henoch's Purpura associated with Angio-neurotic Œdema, A Case of. ALEXANDER DON. (*The Practitioner*, June, 1908, p. 823.)

Hydroa Puerorum (Unna). MARCUS HAASE and ROSE HIRSCHLER. (*Journ. of Cut. Dis.*, May, 1908, p. 199.)

Inflammation of the Skin of the Breast, Some Rare and Persistent Forms of. ADOLFO GALIMBERTI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, xlix, f. 1.)

Lupus Erythematosus and Erythema Multiforme, The Relationship of. J. Galloway and J. M. H. Macleod. (*Brit. Journ. Derm.*, March, 1908, p. 65.)

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Sclerodermia, Ocular Paralyses and Nystagmus in the Course of Generalised. Raymond and Guillain. (*Bull. et Mém. de la Soc. Méd. des Hôp. de Paris*, March 12th, 1908, p. 375.)

Ulcerations of the Fingers, Some Infections (Chancres, Soft Sores, Acute Tuberculous Ulcers) (illustrated). L. Queyrat. (*La Presse Médicale*, June 27th, 1908, p. 411.)

Urticaria Tuberosa, On a Case of. A. Ghelfi. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, xlix, f. 3.)

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